

MEDICATIONS & SUPPLEMENTS

Please list all of the pharmaceutical drugs, over-the-counter medications, supplements, nutritional drinks, and herbal supplements you have used *in the past six (6) months*. Use additional pages or bring these items with you to the consultation if you prefer.

	Currently take?		Dose, Form, Frequency*	What condition do you take this for?	Are you happy with the effects? Do you experience any side effects?
	YES	NO			
Prescription Medications					
Over-the-Counter Medications (e.g., antacids, laxatives, aspirin, Tylenol, Advil, Motrin, Aleve, cough drops, cough syrups, etc.)					

Vitamin/Mineral Supplements or Nutritional Drinks (e.g., energy drinks, protein shakes, etc.)					
Herbal Supplements (please list all herbs included if a formula)					

*DOSE is how many milligrams or units; FORM is capsule, tablet, powder, liquid, etc.; FREQUENCY is how many times per day you take it.